NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

APPLICATION FOR TINTED WINDOW EXEMPTION

Section 375(12-a)(b) of the Vehicle and Traffic Law provides that the front windshield and side windows on both sides of any eligible vehicle that is operated in New York State must allow at least 70% of any light to pass through. The rear window may allow less than 70% of any light to pass through if the vehicle has mirrors on both sides that can be adjusted so the driver has a clear view of the road and traffic conditions behind the vehicle. The rear side windows of any station wagon, sedan, hardtop, coupe, hatchback or convertible must also allow 70% of any light to pass through. A vehicle falls into one of these categories if it is labeled "Passenger Car" on the Federal ID label found on the left front door panel.

The law provides an exemption for any person who, for medical reasons, must be shielded from direct sunlight. The person who requests an exemption may be either the driver or someone who is a regular passenger in the vehicle.

NYS Health Department regulations specify that **only** certain medical conditions can be used to justify an exemption from the limits on light transmittance. A list of these conditions is on page 2.

INSTRUCTIONS:

To request a medical exemption, send the following items to the address at the bottom of this page:

1. This completed application:
   - Page 1 is to be completed by the requestor
   - Page 2 **must** be completed by a physician, physician assistant or nurse practitioner
2. A photocopy of the vehicle registration receipt

***Note:** Based on the medical information submitted, our reviewer may ask for further medical details.

Provide the following information as it appears on the vehicle registration.

Last Name	First	M.I.
Address (*Number and Street*)		Apt. #
City	State	Zip Code

If a medical exemption is requested for someone other than the registered owner of the vehicle, please provide the following information about that person.

Last Name	First	M.I.
Address (*Number and Street*)		Apt. #
City	State	Zip Code

I certify and affirm that all information presented in this form is true and correct, that any documents, including supporting documentation, that I have presented to DMV are true, accurate and genuine. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal offense.

Signature of Vehicle Registrant **X** _____ Date _____

(Sign Name in Full)

Return this application to: Department of Motor Vehicles, Driver Regulation Bureau, Medical Review Unit, 6 Empire State Plaza, Room 337, Albany NY 12228

This side must be completed by your physician/physician assistant/nurse practitioner.

PLEASE PRINT CLEARLY

Patient's Last Name	First Name	M.I.

Date of Birth (Month/Day/Year) / /	☐ Male ☐ Female

1. Examination Date _____/_____/_____ (Must be within one year from the date this form is submitted to the Department of Motor Vehicles.)

2. The following medical conditions, when their existence is certified by a physician, physician assistant or nurse practitioner, justify granting an exemption from the limits on light transmittance found in Vehicle and Traffic Law, section 375(12-a)(b), provided that personal protective measures such as sun protective clothing, sunscreen, eye protective devices or clear UV-protective window films, do not offer adequate protection. Check the medical condition that applies to the above-named patient:

   ☐ albinism

   ☐ chronic actinic dermatitis/actinic reticuloid

   ☐ dermatomyositis

   ☐ lupus erythematosus

   ☐ porphyria

   ☐ xeroderma (pigmentosa) pigmentosum

   ☐ severe drug photosensitivity, provided that the course of treatment causing the photosensitivity is expected to be of prolonged duration

   ☐ photophobia associated with an ophthalmic or neurological disorder

   ☐ any other condition or disorder causing <u>severe</u> photosensitivity in which the individual is required for medical reasons to be shielded from the direct rays of the sun. The medical condition of _____ warrants a tinted window exemption.

Physician/Physician Assistant/Nurse Practitioner's Name (Please print in full)	☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner
Physician/Physician Assistant/Nurse Practitioner's Mailing Address (Include number and street)	

City	State	Zip Code	Telephone Number (area code) ( )

Based on my examination, tinted windows are necessary for my patient's health ☐Yes ☐No	Certificate or Professional License Number	State Where Licensed

I certify and affirm that all information presented in this form is true and correct, that any documents, including supporting documentation, that I have presented to DMV are true, accurate and genuine. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal offense.

Physician/Physician Assistant/Nurse Practitioner's Signature	Date (Month/Day/Year) / /